PREVENTING READMISSIONS THROUGH COMMUNITY HEALTH NURSE APPROACH

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Benchmark Project

PICOT QUESTION

- In adult medical-surgical patients (P), how does implementing a discharge follow up program (I) compared to the standard discharge process (C) affect readmission rates (O) in three months (T)?

RATIONALE

- **Hospital Readmissions**
  - Increase hospital costs
  - Decrease patient satisfaction
  - Worse patient outcomes

- **Connecting hospital to community**
  - Increases nurse satisfaction
  - Improves trust of community
  - Improves overall health of community

Short term goal:

Decrease the rate of hospital readmissions

Long term goal:

Connect the healthcare team with the community

LITERATURE SYNTHESIS

Hospital readmissions increase hospital costs, decrease patient satisfaction and patient outcomes

Hospital readmissions occur due to inadequate discharge education

Discharge phone calls can decrease hospital readmissions

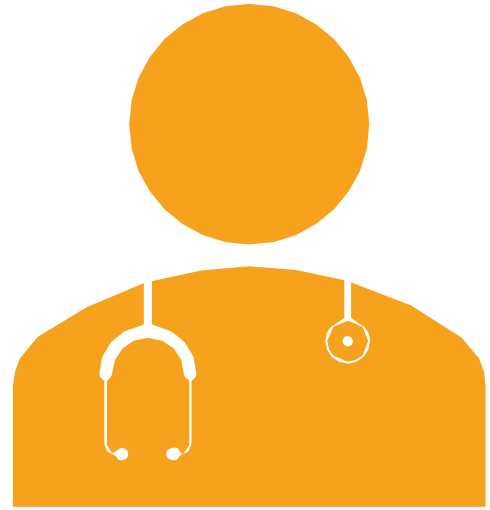
Same bedside nurse with patient relationship to make discharge phone call improves trust with patient

Making multiple calls post-discharge improves patient understanding of medications and disease process

Having a nurse script improves documentation and nurse comfort calling patients

STAKEHOLDERS

- Upper management
  - Chief Nursing Officer
  - Director of Nursing
- Mid-level management
  - Nurse managers
  - Charge nurses
  - Nursing supervisors
- Bedside nurses
- Case management
- Nurse educators
- Patients



IMPLEMENTATION

Identifying patient

Nurse chooses patient based on relationship formed

Must be at least moderate risk of readmission

Collaboration with case management

Patient agrees to receive phone calls about care

Phone calls

Medication reconciliation, follow up appointments, answer questions

Month 1: every week

Month 2: every other week

Month 3: once at the end of the month

TIMETABLE

Research/Design

- Designed from other evidence-based research

Approval

- Approval needed from proper channels

Education

- Weeks 1-2

Implementation

- Weeks 3-15

Evaluation

- Week 16

Dissemination

- Results disseminated to stakeholders

DATA COLLECTION/METHODS

Pre-intervention

- Three months prior to implementation
- Evaluation of readmission rate

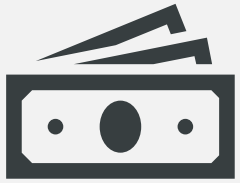
Post-intervention

- Three months after implementation
- Evaluation of readmission rate

COSTS V BENEFITS

COSTS

- Costs associated with education materials
- Bedside nurses will call patients once a week during regular shift hours
- Lock to keep project information in a locker



BENEFITS

- Decreased amount of hospital readmissions
- Decreased hospital costs
- Increased nurse satisfaction
- Improved patient health outcomes

DISCUSSION

DISCHARGE PHONE CALLS CAN DECREASE HOSPITAL READMISSIONS

SUPPORT RECEIVED FROM UNIT NURSES AND STAKEHOLDERS

AWAITING FOR PROPER APPROVAL PROCESS

RECOMMENDATIONS

- Any unit with discharged patients should implement a nurse-led telephone follow up program
- Ensure there is support from leadership
- Feedback from shared governance councils
- Utilize resources available

THANK YOU

REFERENCES

Bradas, C. (2016). Characteristics and Predictors of Readmission to a Medical Short-Stay Unit. *MEDSURG Nursing*, *25*(6), 397–401

Briscoe, G.T., Heerschap, A., Kane, C.F., & Quatrara, B.D. (2018). Using post-discharge telephone follow-up by nephrology nurses to reduce 30-day readmissions and postdischarge complications for adult patients on hemodialysis. Nephrology Nursing Journal, 45(3), 243-248, 267 .

Dizon, M. L., & Reinking, C. (2017). Reducing Readmissions: Nurse-Driven Interventions in the Transition of Care From the Hospital. *Worldviews on Evidence-Based Nursing*, *14*(6), 432–439

Harris, S. (2016). Reducing 30-Day Readmissions for Chronic Obstructive Pulmonary Disease. *MEDSURG Nursing*, *25*(6), 403–422.

Harrison, J. D., Auerbach, A. D., Quinn, K., Kynoch, E., & Mourad, M. (2014). Assessing the impact of nurse post-discharge telephone calls on 30-day hospital readmission rates. *JGIM: Journal of General Internal Medicine*, *29*(11), 1519–1525.

Heitkam, R. (2019). Reducing hospital readmissions through faith community nursing. *Nursing Management*, *50*(8), 26–30.

Hospital Readmissions Reduction Program (2019). Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program (Links to an external site.)

Hoyer, E. H., Brotman, D. J., Apfel, A., Leung, C., Boonyasai, R. T., Richardson, M., Lepley, D., & Deutschendorf, A. (2018). Improving Outcomes After Hospitalization: A Prospective Observational Multicenter Evaluation of Care Coordination Strategies for Reducing 30-Day Readmissions to Maryland Hospitals. *JGIM: Journal of General Internal Medicine*, *33*(5), 621–627.

Kenney-Lueptow, J. (2020). Inpatient Navigation: Utilizing Nurse Navigation Principles to Transition Patients Through Hospitalization, Discharge, and Outpatient Care. *Journal of Oncology Navigation & Survivorship*, *11*(1), 7–13.

Luther, B., Wilson, R. D., Kranz, C., & Krahulec, M. (2019). Discharge Processes: What Evidence Tells Us Is Most Effective. *Orthopaedic Nursing*, *38*(5), 328–335.

McLaughlin, F., Henn, J., & Candelario, D. (2017). Reduce readmissions and improve transitional care services. *American Nurse Today*, *12*(12), 44–46

Strait, L. A., Fitzgerald, E., Zurmehly, J., & Overcash, J. (2019). A Congregation Transition of Care Program Using Faith Community Nurses and Volunteer Faith-Based Nurses. *Journal of Christian Nursing*, *36*(3), 158–165

Thomas, D. V., & Siaki, L. A. (2017). A Partnership for Patients Initiative: Redesigning a Medical-Surgical Unit's Discharge Process to Reduce Readmissions. *Nursing Economic$*, *35*(2), 76–87

Yiadom, M. Y. A. B., Domenico, H., Byrne, D., Hasselblad, M. M., Gatto, C. L., Kripalani, S., Choma, N., Tucker, S., Wang, L., Bhatia, M. C., Morrison, J., Harrell, F. E., Hartert, T., & Bernard, G. (2018). Randomised controlled pragmatic clinical trial evaluating the effectiveness of a discharge follow-up phone call on 30-day hospital readmissions: balancing pragmatic and explanatory design considerations. *BMJ Open*, *8*(2), e019600


Nurse identifies patient
• Patient must be at least moderate risk according to electronic medical record
• Case management gives approval
• Patient has disease process that requires follow up (EX: Diabetes Mellitus, Congestive Heart Failure)
• Patient agrees to participation
Week 1 Post Discharge
• Nurse attempts to call patient. If patient does not answer the second attempt, nurse to leave voicemail
• Nurse reconciles medications, answers patient questions, ensures patient is able to go to follow up appointments
• Nurse documents in electronic medical record telephone call or attempted telephone call
Week 2 Post Discharge
• Nurse attempts to call patient. If patient does not answer the second attempt, nurse to leave voicemail
• Nurse reconciles medications, answers patient questions, ensures patient is able to go to follow up appointments
• Nurse documents in electronic medical record telephone call or attempted telephone call
• [Text]
Week 3 Post Discharge
• Nurse attempts to call patient. If patient does not answer the second attempt, nurse to leave voicemail
• Nurse reconciles medications, answers patient questions, ensures patient is able to go to follow up appointments
• Nurse documents in electronic medical record telephone call or attempted telephone call
Week 4 Post Discharge
• Nurse attempts to call patient. If patient does not answer the second attempt, nurse to leave voicemail
• Nurse reconciles medications, answers patient questions, ensures patient is able to go to follow up appointments
• Nurse documents in electronic medical record telephone call or attempted telephone call
Week 6 Post Discharge
• Nurse attempts to call patient. If patient does not answer the second attempt, nurse to leave voicemail
• Nurse reconciles medications, answers patient questions, ensures patient is able to go to follow up appointments
• Nurse documents in electronic medical record telephone call or attempted telephone call
Week 8 Post Discharge
• Nurse attempts to call patient. If patient does not answer the second attempt, nurse to leave voicemail
• Nurse reconciles medications, answers patient questions, ensures patient is able to go to follow up appointments
• Nurse documents in electronic medical record telephone call or attempted telephone call
Week 12 Post Discharge
• Nurse attempts to call patient. If patient does not answer the second attempt, nurse to leave voicemail
• Nurse reconciles medications, answers patient questions, ensures patient is able to go to follow up appointments
• Nurse documents in electronic medical record telephone call or attempted telephone call

Appendix A

Appendix B

Post-discharge Nurse Phone Call Script

Nurse Name: _____

Pt MRN: _____

Week number phone call: _____

Suggested Questions:

- How have you been feeling since you discharged from the hospital?
- Were you able to pick up your medications from the pharmacy?
- How have you been taking your medications? Re-educate as needed.
- Can you list the side effects of your new medications? Re-educate as needed.
- Do you understand why you are taking these medications?
- Have you had any follow up appointments since your discharge/since we last spoke?
- Are there any barriers to you getting to your follow up appointments?
- What was said? Do you have any questions regarding what the physician may have said?
- Do you have any questions regarding <admitting disease process>?

Questions you do not know the answer to?

THAT'S OKAY! Ask the patient if you can call them back at another time after you clarify information. If needed, it is okay to call their doctor or pharmacy for clarification.

Is the patient needing additional resources?

Don't forget about case management. It is okay to talk with the case manager about possible available community resources to help out our patients with whatever is needed.

DOCUMENT! During your phone call, add a Telephone call encounter in the patient's chart. There will be a template to document what was discussed with the patient that goes along with the above suggested questions. Document what the patient states and what the response was under the telephone call encounter. Document all attempts to reach the patient.

If you need to leave a voicemail message, only leave the following information:

Patient name, Your name, phone number to call back, and that you are calling from Baylor Scott and White. Do not mention the specific facility.

(Ctrl)

Appendix C

MRN	Call 1 (Week 1)	Call 2 (Week 2)	Call 3 (Week 3)	Call 4 (Week 4)	Call 5 (Week 5)	Call 6 (Week 6)	Call 7 (Week 7)	Call 8 (Week 8)	Readmission Date

Record the date under each week when the patient has been successfully contacted.

Appendix C